Introduction to Cost Growth Benchmarks

Nevada Patient Protection Commission

March 15, 2021

bailit health

Topics

1. What Is a Cost Growth Benchmark, Why Pursue One, and Its Impact on Health Care Costs
2. Review of Other States' Health Care Cost Growth Benchmark Programs
3. Cost Growth Benchmarks Amid The COVID-19 Pandemic
4. Meeting Timeline

What is a cost growth benchmark and why pursue one?

- A health care cost growth benchmark is a per annum rate-of-growth target for health care costs for a given state.

Per Capita Health Care Cost Growth 2018-2019: 4.1%[1]

GDP Growth 2018-2019: 4.0%[2]

Average Wage Growth 2018-2019: 3.3%[3]

SOURCES:

1) Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, accessed February 17, 2021.
2) U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/GDP, February 16, 2021.
3) U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private [CES0500000003], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CES0500000003, February 16, 2021.

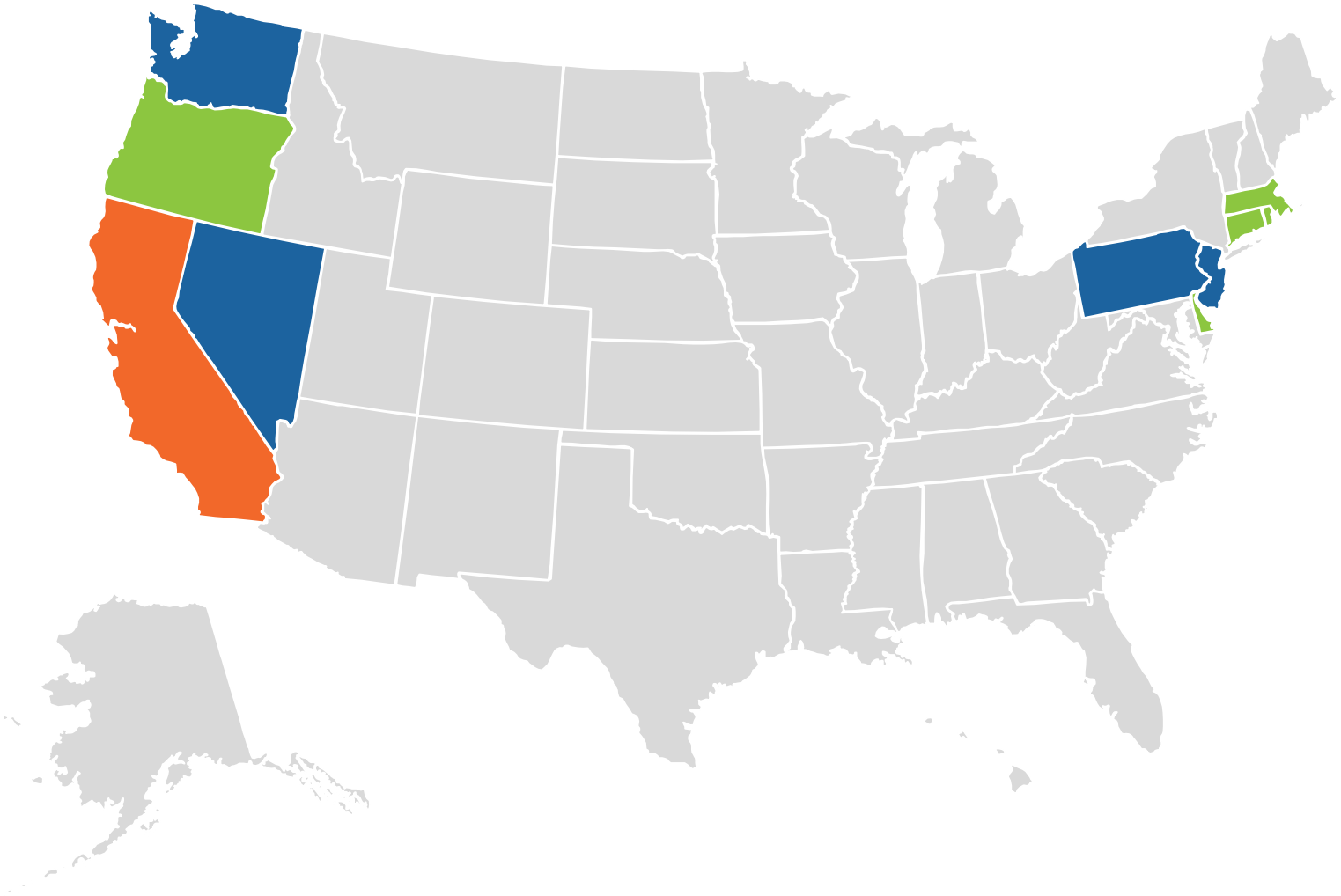
A note on terminology

- States use different terminology, with some using “benchmark” and others using “target.” They are treated in other states as synonyms.

“Benchmark”	“Target”
• Connecticut • Delaware • Massachusetts • Washington	• Oregon • Rhode Island

State activity on health care cost growth benchmarks

- Established (CT, DE, MA, OR, RI)
- Committed to development (NJ, NV, PA, WA)
- Active discussions underway (CA)

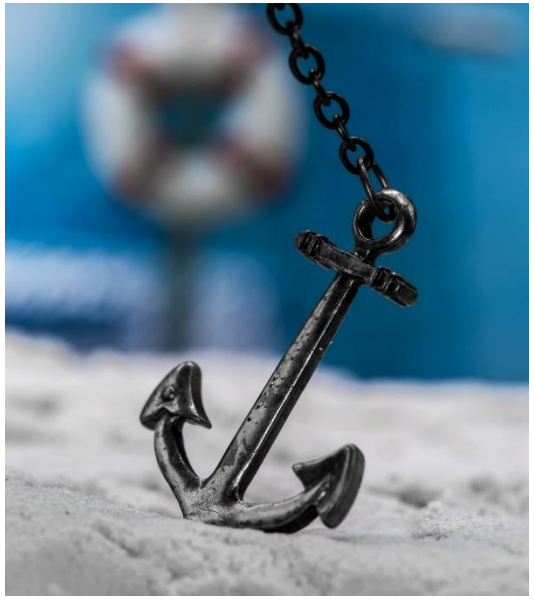


States pursued cost growth benchmarks to curb health care spending growth

- **MA:** State-purchased health care rose 40% over 12 years while spending on other services was reduced by 17% on average.
- **OR:** health insurance premiums cost 29% of a family's total income.
- **DE:** the State's per capita total health spending was the 3rd highest in the nation.
- **RI:** 7 of 10 health insurance filings in the large and small group market outpaced annual wage growth.
- **CT:** health care costs outpaced growth in the State's economy, with personal health care expenditures taking up a larger portion of the State's GDP.

The logic model for a cost growth benchmark

- Setting a public target for health care spending growth alone will not slow rate of growth.
- A cost growth target serves as an anchor, establishing an expectation that can serve as the basis for transparency at the state, insurer and provider levels.



- To be effective, it must be complemented by supporting strategies if it is likely to be effective.

The logic model for a cost growth benchmark

Transparency

Public reporting of performance serves as a strong incentive to achieve the benchmark

Accountability (sometimes)

Some states include PIPs and/or penalties for failure to meet the benchmark

Cost Growth Benchmark

Accompanying analyses shed light on the factors driving cost growth

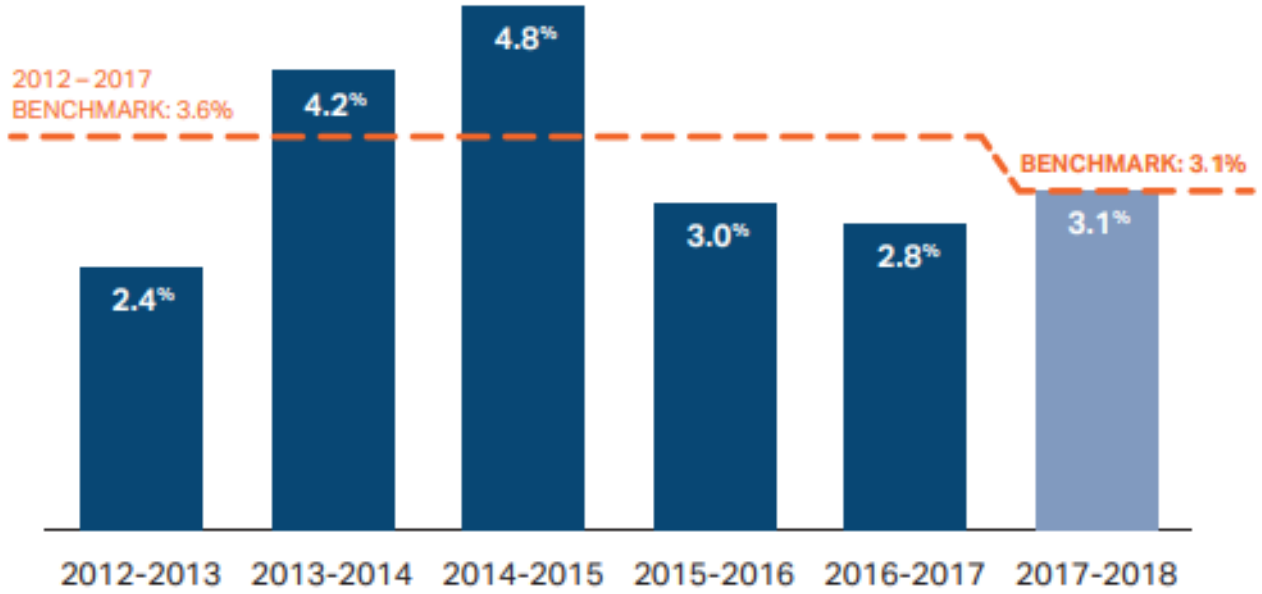
Cost Driver Analysis

Setting benchmarks help spur activities and initiatives designed to reduce health care cost growth

Policy Initiatives

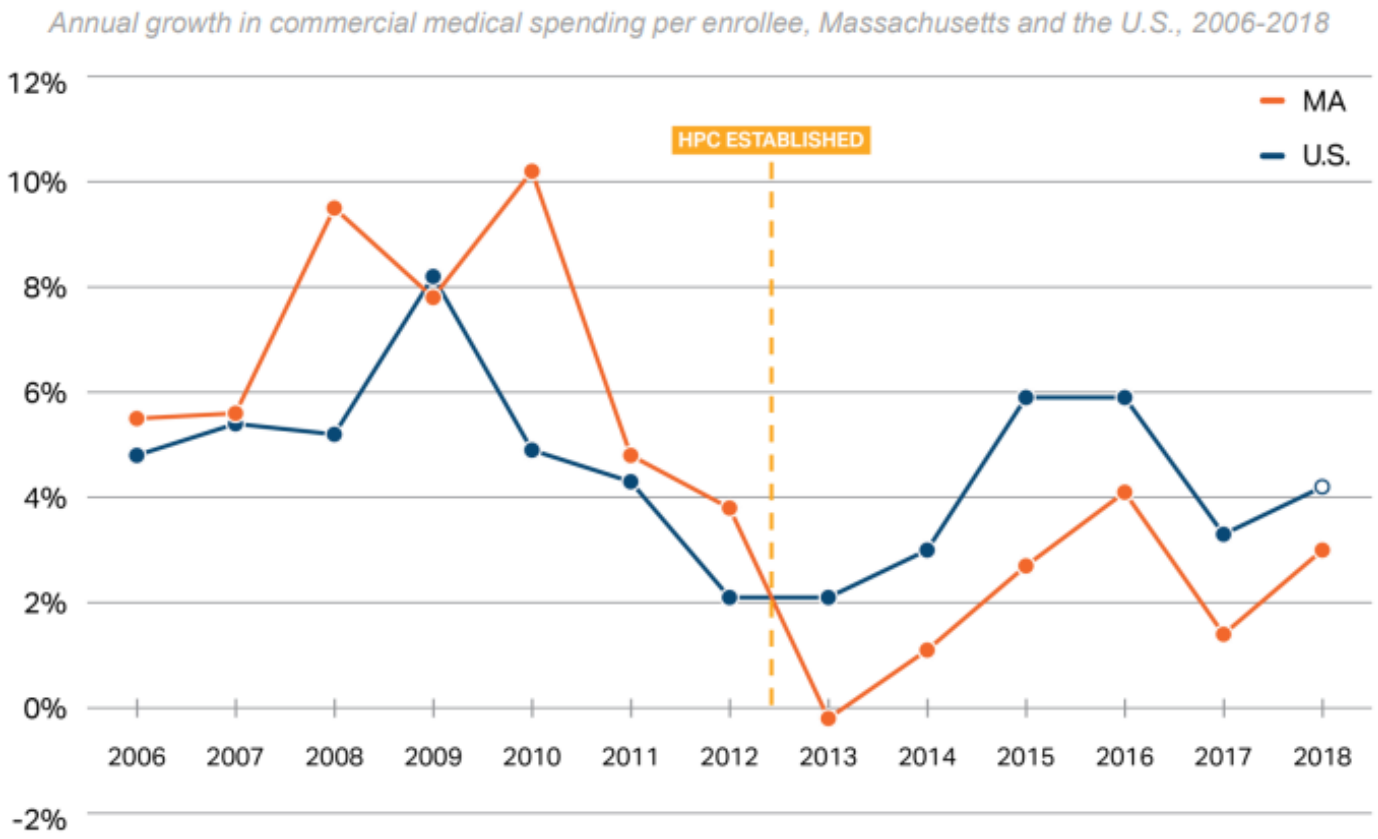
Massachusetts' cost growth benchmark experience

Since establishing the cost growth benchmark in 2012, annual all-payer health care spending growth has averaged the cost growth benchmark level, and has been below the U.S. average.



SOURCE: Massachusetts Health Policy Commission, 2019 Annual Health Care Cost Trends Report, February 2020.

Massachusetts' cost growth benchmark experience



Commercial spending growth in MA has been below the national rate every year since 2013.

SOURCE: Auerbach, David. "Health Care Spending Trends and Impact on Affordability." Presentation, 2019 Health Care Cost Trends Hearing, October 22-23, 2019.

The cost growth benchmark's impact in Massachusetts

Common goal

Payers and providers have aligned on a common target for reducing health care cost growth.

Total cost of care approach

The benchmark is consistent with a TCOC contracting approach which has become the common contracting structure.

Influence on negotiations

Negotiations between payers and providers have been influenced by the benchmark, thereby tempering price growth.

Transparency

Reasons for cost growth have been studied and publicized, keeping the policy and its consequences in the public eye.

Policy experts' assessment of the cost growth benchmark's impact in MA

"With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%"

- David Cutler, HPC member

"The [cost growth target]…sets the bar upon which most activities in the health system are judged. It's more than just a symbol, it's become an operational component of how our health system works."

- Stuart Altman, HPC Chair

"Payer and provider rate negotiations are now conducted in light of the 3.6% target"

- State Auditor study

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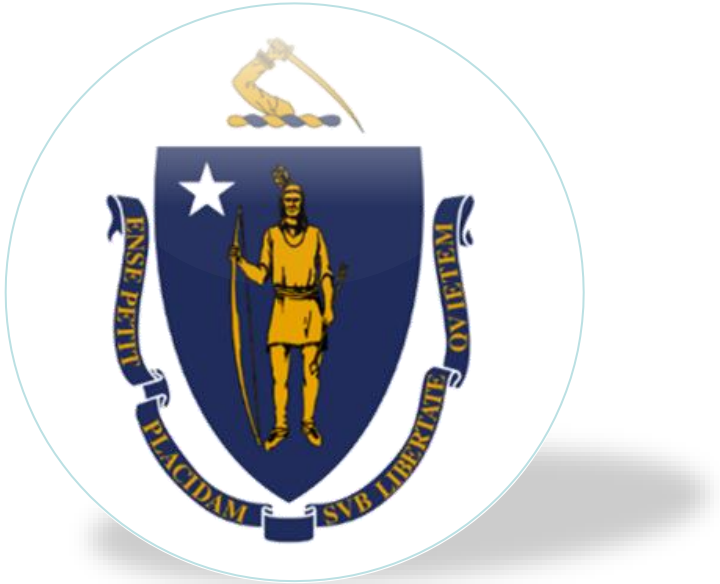
Review of other states' cost growth benchmark programs

- To date, five states have established health care cost growth benchmarks (MA, DE, RI, OR, CT).
- For each of these states we will review:
  - Enabling legislative, regulatory or administrative requirements
  - Benchmark values and supporting methodology
  - Assessment of performance assessment against the benchmark:
    - Measurement of health care costs
    - Data sources
    - Statistical testing
  - Accountability and enforcement mechanisms



Massachusetts' Health Care Cost Growth Benchmark Program

Enabling legislative, regulatory or administrative requirements

- Chapter 224 of the Acts of 2012 established health care cost growth benchmarks as part of sweeping health system reforms.
- Chapter 224 created two entities:
  - Health Policy Commission (HPC) to set and enforce the benchmark
  - Center for Information and Analysis (CHIA) to collect and measure health system performance against the benchmark.

Cost growth benchmark values and methodology

- Benchmarks are set in statute and pegged to Potential Gross State Product (PGSP), a forecasted average growth rate of the state's economy, according to the following rules:
  - 2013 – 2017: equivalent to PGSP (calculated at 3.6%)
  - 2018 – 2022: PGSP minus 0.5% (or 3.1%), unless the HPC votes that an adjustment is warranted (requires 2/3 majority)
  - 2023 and beyond: equivalent to PGSP, with authority for the HPC to adjust it to any value

Assessment of performance against the benchmark

- Measured using Total Health Care Expenditures (THCE) by and for MA residents from public and private sources, which consist of:
  - Total Medical Expense (TME) spending on all medical services for all MA residents regardless of where care was provided, including non-claims-related payments to providers;
  - Patient cost-sharing; and
  - Net Cost of Private Health Insurance (NCPHI), a measure of the costs to MA residents associated with administration of private health insurance (including Medicare Advantage and Medicaid managed care).

Assessment of performance against the benchmark

- THCE does not include:
  - Non-medical spending made by payers (e.g., gym membership);
  - Vision or dental care not otherwise covered by a medical plan; or
  - Expenditures recorded by providers, but not insurers (e.g., spending for uninsured residents).

Assessment of performance against the benchmark

- Commercial insurers submit TME summary-level information, including:
  - "Allowed amount" expenditures made on behalf of MA residents, which includes patient cost-sharing
  - Fully-insured and self-insured plans
  - Medicare Advantage, Medicaid MCOs, and dual eligible products
  - Payer completion factor adjustment to estimate costs that have been incurred but not reported (IBNR)
- For carved-out services (behavioral health, pharmacy), CHIA makes actuarial adjustments.

Assessment of performance against the benchmark

- CHIA also collects medical expenses for other payers that don't report TME, including:
  - Medicaid primary care case management program and other fee-for-service data from the Medicaid agency
  - Medicare Part A and/or B and stand-alone Part D membership and expenditure data from CMS
  - Other sources of health spending (e.g., Veterans Health Administration)

Accountability and enforcement of the benchmark

- On an annual basis, CHIA publicly reports performance at four levels:
  - State
  - Market (i.e., Commercial, Medicare, Medicaid)
  - Payer or insurer
  - Provider entity

Accountability and enforcement of the benchmark

- The HPC can require providers whose cost growth exceeds the benchmark to:
  - Implement a performance improvement plan (PIP); and
  - Levy penalties of up to $500,000 for noncompliance with the PIP.
- In years when the State exceeds the benchmark, the HPC may conduct a review of one or more provider entities.
- To date, there have been referrals, but *no PIPs*.

Delaware's Health Care Spending and Quality Benchmarks Program

Enabling legislative, regulatory or administrative requirements

- In September 2017, the Delaware Legislature passed House Resolution 7 to establish and plan for the monitoring and implementation of an annual healthcare benchmark.
- In November 2018 Governor Carney issued Executive Order 25 to formally establish the health care spending and quality benchmarks.
- The DE Health Care Commission (DHCC) and DE Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Committee oversee the program.

Health care spending benchmark values and methodology

- The benchmark is set at the State's PGSP (3.0%) with transitional adjustments.
  - 2019: 3.8%
  - 2020: 3.5%
  - 2021: 3.25%
  - 2022 and 2023: 3.0%
- Annually, a DEFAC subcommittee reviews all PGSP components and recommends whether material changes and warrant a change in the target.
  - By March 2023, it will consider whether to change the target's methodology for future years by.

Rhode Island's Health Care Cost Growth Target Program

Enabling legislative, regulatory or administrative requirements

- In 2016, at Governor Raimondo's request, a group of health leaders recommended a method for setting a cost growth target for the State.
- After a long delay, foundation funding helped launch a more public effort to establish a target and analyze the State's APCD to highlight spending patterns and trends.
- In August 2018, the State convened a Steering Committee of 18 diverse RI stakeholders to develop recommendations on a target.

Enabling legislative, regulatory or administrative requirements

- The Steering Committee made recommendations and in December 2018 signed a voluntary compact to meet the benchmark, which is in effect through December 2022.
- Governor Raimondo established the target through Executive Order 19-03 in February 2019.
- The State administers the program, with ongoing advice and support from its stakeholder Steering Committee.

Cost growth target values and methodology

- The Steering Committee established the target, which is set to the State's PGSP as calculated in 2018.
  - 2019 – 2022: 3.2%
  - 2023 and beyond: to be re-evaluated and determined in 2022
- The methodology can be revisited under highly significant changes in the economy, with the Steering Committee working with the State to determine a functional definition of "highly significant."
- The target is coupled with a data use strategy leveraging the APCD to give policymakers and providers information to manage health care cost growth.

DE and RI's benchmark programs are largely modeled off MA

- DE and RI use THCE to measure performance against the benchmark.
- Insurers submit per member per year TME for the commercial fully and self-insured, Medicare Advantage, and Medicaid managed care.
- Both states will publish performance at the state, market, insurer and provider entity levels for the purposes of transparency.
- We will review the details that vary by state when we discuss key design decisions for NV's program.

Oregon's Sustainable Health Care Cost Growth Target Program

Enabling legislative, regulatory or administrative requirements

- In June 2019, the OR legislature passed SB 889 to establish a cost growth target program.
- SB 889 charged the OR Health Authority (OHA), in collaboration with the Department of Consumer and Business Services (DCBS) and the OR Health Policy Board (OHBP), to develop and implement the program.
- It created a stakeholder-populated Implementation Committee to oversee program details, with broad and flexible authority.

Cost growth target values and methodology

- The Implementation Committee based its target on historical gross state product (GSP), median wage, and the growth "cap" in OR's Medicaid and publicly purchased programs.
  - 2021 – 2025: 3.4%
  - 2026 – 2030: 3.0%
- In 2024, a to-be-determined advisory body will review historical PGSP and median wage trend to determine the appropriateness of the 2026-2030 target and make recommendations to the OHPB.

Assessment of performance against the target

- Similar to MA, DE and RI, OR assesses performance against the benchmark using THCE.
- Unlike in these other states, THCE includes spending on OR residents by the Indian Health Service and in a state correctional facility (to the extent data are accessible).
- In addition, OR will conduct statistical testing to determine whether the target has been met.

Accountability and enforcement of the target

- OR will report performance against the benchmark at all four levels (state, market, payer, provider entity).
- A bill currently before the OR legislature proposes that OR will apply an “escalating accountability mechanism” for payers or provider organizations who exceed the target *without a reasonable basis*.
  - Initially payers or provider organizations that don’t meet the target will be subject to PIPs.
  - Those that don’t meet the target in 3 out of 5 years (on a rolling basis) will be subject to a financial penalty.

Accountability and enforcement of the target

- In addition, OHA may:
  - Assess fines for late or incomplete data and/or PIPs.
  - Apply accountability measures earlier for payers or provider organizations not engaging in the program.

Connecticut's Health Care Benchmark Initiative

Enabling legislative, regulatory or administrative requirements

- In January 2020, Governor Lamont's Executive Order #5 directed the Office of Health Strategy (OHS) to develop health care cost growth benchmarks for 2021-2025, quality benchmarks and primary care spend targets.
- Executive Order #5 directs OHS to convene a "Technical Team," including representatives from various state agencies and other health care stakeholders to advise on benchmark program policies.
- OHS also convenes a Stakeholder Advisory Board – a broader group of stakeholders – to provide input to the Technical Team.

Cost growth benchmark values and methodology

- The Technical Team established a benchmark based on 20/80 blend of the growth in forecasted PGSP and forecasted median income, with an add-on factor in the first two years.
  - 2021: 3.4%
  - 2022: 3.2%
  - 2023 – 2025: 2.9%
- OHS may revisit the methodology and calculation should there be a sharp rise in inflation between 2021 and 2025.

Assessing performance against the benchmark

- CT assesses performance against the benchmark using THCE, similar to other states.
- Key differences from some other states are that THCE includes:
  - Spending on CT residents through the Veterans Health Administration.
  - Spending on CT residents in state correctional facilities.
- Similar to OR, CT will apply statistical testing to determine if payers or provider entities met the benchmark.

Accountability and enforcement of the benchmark

- Similar to other states, CT will publicly report performance at the state, market, payer and provider entity levels.
- There are no financial penalties associated with not meeting the benchmark.

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COVID-19's impact on health care spending

- Health services revenue fell by 2.4% compared to 2019 (compared to a 5% increase from 2018 to 2019).
- Spending on health services dropped sharply in March and April but mostly recovered by October 2020.
- As of the 3rd quarter of 2020, the largest drops in spending were in ambulatory care settings.
- Hospital admissions fell in spring 2020 but were back to about 95% by July.
- Little yet is known about the fall surge's impact on health care spending.

SOURCE: Cox, C and Amin, K, "How Have Health Spending and Utilization Changed During the Coronavirus Pandemic?" Peterson-KFF Health System Tracker, December 1, 2020.

Consideration of the COVID-19 experience when setting the benchmark value

- The benchmark's intended use is to establish a stable, multi-year expectation for spending growth.
- Unusual events – including a pandemic – may cause occasional and time-limited fluctuations in spending.
- Providers and plans should not be penalized for increased spending associated with COVID-19.
- MA, DE and RI all kept their benchmarks in place, and CT and OR did not modify theirs for COVID-19.

How will COVID-19 impact Nevada's policy?

- The Commission will need to weigh whether to consider the pandemic's anticipated economic impact when setting the benchmark.
- We now have a partial understanding of how the pandemic affected 2020 spending.
  - 2022 trend could be aberrant due to the impact of COVID-19 on 2021 utilization.

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Meeting Timeline

Meeting Number	Meeting Date	Key Topics	
Commission Meeting #1 (2-hour meeting)	March 15, 2021	• Welcome and introduction of benchmark charge • Member and staff introductions • Introduction to cost growth benchmarks, including their use in other states • Review of planned process for benchmark development • Discussion of process for soliciting stakeholder input • Public comment • Wrap-up	(10 minutes) (15 minutes) (45 minutes) (25 minutes) (15 minutes) (5 minutes) (5 minutes)

Commission Meeting #2	April 21, 2021	• PPC recommended principles and operating procedures for benchmark strategy development
		• Cost growth benchmark methodology
		  ○ Defining Total Health Care Expenditures (THCE)
		  ○ Determining whose THCE to measure (residence and source of coverage)
		  ○ Criteria for selecting an indicator for the cost growth benchmark	

Advisory Subcommittee Meeting #1	Date TBD	• Introduction, orientation to cost growth benchmarks • Review role vis-à-vis the PPC • Review detailed meeting plan • Review landscape of similar activity in other states, and data on existing growth trends	

Meeting Timeline

Meeting Number	Meeting Date	Key Topics

Commission Meeting #3	May 19, 2021	• Cost growth benchmark methodology (continued)
		  ○ Economic indicators that could be used to set a benchmark
		  ○ Use of historical vs forecasted values
		  ○ Adjustments to the benchmark
		  ○ Possible benchmark values

Advisory Subcommittee Meeting #2	Date TBD	• Review PPC deliberations on measurement of total health care expenditures and cost growth benchmark methodology • Gather feedback to share with the PPC

Commission Meeting #4	June 16, 2021	• Recommendations on the benchmark methodology, including benchmark values
		• Performance assessment
		  ○ How performance against the cost growth benchmark will be measured at the state, market, provider entity, and per capita levels
		  ○ Provider attribution to health care entities
		  ○ Patient attribution to providers

Advisory Subcommittee Meeting #3	Date TBD	• Review PPC deliberations on benchmark methodology and values, and on performance assessment • Gather feedback to share with the PPC

Meeting Timeline

Meeting Number	Meeting Date	Key Topics

Commission Meeting #5	July 21, 2021	• Performance assessment (continued)
		  ○ Minimum payer and provider size for reporting data to the State
		  ○ Minimum payer and provider size for reporting performance against the benchmark
		  ○ Mechanisms for risk adjusting performance against the benchmark
		  ○ Methodology for calculating annual percentage change of Total Health Care Expenditures
		• Authority and governance of benchmarks

Advisory Subcommittee Meeting #4	Date TBD	• Review PPC deliberations on performance assessment, and on authority and governance of benchmarks • Gather feedback to share with the PPC

Commission Meeting #6	August 18, 2021	• Transparency and accountability
		  ○ Frequency of public reporting
		  ○ Format of reporting
		  ○ Elements to be included in reporting
		• Data use strategy
		  ○ Use of Medicaid state employee health plan claims and other data to identify health care cost and cost growth driver
		  ○ Primary audience for analyses

Advisory Subcommittee Meeting #5	Date TBD	• Overview of the goals and purpose of a data use strategy • Review PPC deliberations on transparency and accountability, and on data use strategy goals and potential analyses • Gather feedback to share with the PPC

Meeting Timeline

Meeting Number	Meeting Date	Key Topics
Commission Meeting #7	September 15, 2021	• Cost growth mitigation strategies to ensure the benchmark strategy is successful • Unfinished topics
Advisory Subcommittee Meeting #6	Date TBD	• Overview of cost growth mitigation strategies to ensure the benchmark strategy is successful • Gather feedback to share with the PPC

Commission Meeting #8	October 20, 2021	• Review draft Commission recommendations
		• PPC benchmark process for 2022 and beyond
		• Implementation strategy
		  ○ Baseline evaluation timeline and process
		  ○ Implementation activities (e.g., provider directory development, etc.)

Advisory Subcommittee Meeting #7	Date TBD	• Review draft Commission recommendations • Review PPC discussions of the benchmark implementation strategy • Gather feedback to share with the PPC
Commission Meeting #9	November 17, 2021	• Approve final recommendations